Public Employees Health Programs
560 East 200 South, Suite 100 / Salt Lake City, Utah 84102-2004
Term Life: (801) 366-7495 / Toll Free (800) 753-7495

Group Term Life
Change Form

Section A - *Employee Information*

Employee Name (First, Middle, Last)	Daytime Phone	Birth Date (mm/dd/yy)	Social Security Number

Section B - *Beneficiary Change*

EMPLOYEE TERM LIFE

Revoking any previous nominations of beneficiary(ies), I hereby designate the following individuals to receive all benefits payable upon my death.

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip

SPOUSE TERM LIFE

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip

DEPENDENT CHILD TERM LIFE

Full Given Name of Beneficiary	Designation	Relationship	Birth Date	Mailing Address
	☐ Primary ☐ Contingent			Street City State Zip
	☐ Primary ☐ Contingent			Street City State Zip

Section C - *Dependent Addition or Termination*

ADDITIONS for existing coverage within 60 days of qualifying event

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS TO BE COVERED (last, first, middle initial)	GENDER	BIRTH DATE			DEPENDENT SOCIAL SECURITY NO.
CODE KEY C - Child Natural / Adopted SC - Stepchild			☐M ☐F				
			☐M ☐F				
			☐M ☐F				
			☐M ☐F				

TERMINATIONS

RELATIONSHIP TO EMPLOYEE		DEPENDENTS TO NO LONGER BE COVERED (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (i.e. marriage, divorce, death, age of 26, etc.)	APPLICABLE DATE* MONTH	DAY	YEAR
CODE KEY S - Spouse C - Child Natural / Adopted SC - Stepchild O - Other							

*** Applicable date could be date of marriage, divorce, birthday, etc.**

EMPLOYEE SIGNATURE	DATE